NUTRITION ASSESSMENT FOR WOMEN

CPA/Nutritionist Follow-Up Questions

Required Follow-Up Questions	P	B	N
1. What have you heard about breastfeeding?	X		
2. What concerns related to breastfeeding do you have? **[602]** ☐ Severe breast engorgement ☐ Recurrent plugged ducts ☐ Mastitis (fever or flu-like symptoms with localized breast tenderness) ☐ Flat or inverted nipples ☐ Cracked, bleeding or severely sore nipples ☐ Age ≥ 40 years ☐ Failure of milk to come in by 4 days postpartum ☐ Tandem nursing (breastfeeding two siblings who are not twins) ☐ Other/Comments:		X	
3. Tell me about your current appetite. **[427.2]** ☐ Good appetite ☐ Poor appetite ☐ Concerned ☐ Not concerned ☐ Other/Comments:	X	X	X
4. Tell me about the minerals or herbal supplements you take? **[427.1] [427.4]** ☐ Iodine ☐ Folic Acid ☐ Iron Supplement ☐ Herbal Supplement ☐ None ☐ Other/Comments:	X	X	X
5. Do you use iodized salt? ☐ Yes ☐ No **[427.4]**	X	X	
6. What concerns do you have about providing, preparing and/or storing food for your family? **[902]** ☐ Inadequate kitchen appliances ☐ Frequently have insufficient food resources/sources of assistance ☐ Don't know how to cook ☐ Need new ideas ☐ No concerns ☐ Other/Comments:	X	X	X
7. Tell me how you feel about your weight during pregnancy. *(weight gain in pregnancy; weight/goal/strategies to achieve)* ☐ No concerns ☐ Low weight gain ☐ High weight gain ☐ Other/Comments:	X		
8. Tell me how you feel about your weight since delivery. ☐ No concerns ☐ Low weight gain ☐ High weight gain ☐ Other/Comments:		X	X
9. What health or medical issues do you currently have or had have? **[341-362]**	X	X	X

Required Follow-Up Questions	P	B	N
10. What word(s) describe your emotions this past week? (Check all that apply) ☐ Ok ☐ Tired ☐ Difficulty Concentrating ☐ Difficulty remembering details ☐ Happy ☐ Depressed ☐ Sad ☐ Stressed ☐ Angry ☐ Other/Comments:	X	X	X
11. What concerns do you have about your safety? *(ask when they are alone)* ☐ No concerns ☐ Participant was not alone, question skipped ☐ Other/Comments:	X	X	X
12. Optional documentation if needed. ☐ Other/Comments:	X	X	X
13. How would you like to improve your eating and/or physical activity habits? (*May use for developing a participant centered goal)* Previous Goal Met: ☐ Yes ☐ No ☐ N/A	X	X	X
14. What is the full name and WIC title of the person who completed the assessment?	X	X	X